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# The prescription charge and Hinchcliffe Committee

**Darrin Baines** MSc, PhD

**In our series on the history of prescribing policy, Professor Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the introduction of the prescription charge and the recommendations made by the Hinchcliffe Committee.**

## KEY EVENTS

- 1949 Joint Committee on Prescribing established – six categories for evaluating the appropriateness of using particular classes of drugs were recommended
- 1952 Prescription charge introduced – Winston Churchill's Conservative government implemented the charge at a rate of one shilling for each form issued
- 1956 Prescription charge changed – payment was altered to one shilling per item as a means of removing the incentive for GPs to increase the number of items prescribed
- 1957 Voluntary Price Regulation Scheme introduced – the scheme was implemented for a trial period of three years, with planned £750 000 annual savings
- 1957 Hinchcliffe Committee was appointed – it investigated factors contributing to the rise in drug costs and made suitable policy recommendations

With the introduction of the NHS in 1948, the UK government experienced an unexpected increase in the demand for healthcare, notably for ophthalmic and pharmaceutical services. In response to the rapid growth in the prescription of branded drugs by general practitioners, the Central and Scottish Health Services Councils established the Joint Committee on Prescribing in 1949.

Soon after its appointment, the committee (chaired by Sir Henry Cohen) sent a letter to all GPs suggesting that significance savings could be made if many proprietary brands were prescribed as their standard (generic) alternatives.

Following its investigation, the committee's interim report in June 1950 suggested that absolute restrictions on NHS prescribing were impracticable and that GPs should remain free to prescribe any drugs that they believed necessary for their patients.

Although it advocated prescribing freedom for GPs, in 1954 the Joint Committee's final report recommended a framework for evaluating the appropriateness of using particular classes of drugs within the NHS.[1] Within this framework, pharmaceutical products were classified into six main groups:

1. new drugs of proved therapeutic value but not yet standard
2. proprietary brands of standard drugs
3. standard preparations in elegant forms or vehicles
4. modifications not therapeutically superior to existing preparations
5. preparations of unproven therapeutic value
6. preparations that were a combination of 4 and 5.

In its final report, the committee recommended that drugs classifiable under category 1 should be freely prescribable, drugs in the second, third and fourth categories should only be available subject to satisfactory price arrangements with the manufacturers, and drugs in the penultimate and final categories should not be prescribed.

## The approved list

Following the Joint Committee's report, the Chief Medical Officer produced a list of some 5000 products that were recommended for prescription on the NHS. In order to improve their prescribing, the 'approved list' was sent to all GPs with an accompanying letter that suggested that excluded preparations should only be prescribed once the practitioner had 'ascertained the cost and compared it with that of identical or similar standard preparations'.[2]

As compliance with the list was voluntary, the Chief Medical Officer was unable to guarantee that its distribution would have the desired effects. Indeed, the *British Medical Journal* commented that 'for the already paper bound general practitioner one wonders if the irritation of more printed reference matter will defeat its purpose'.[2]

Given their limited ability to control GP prescribing patterns and costs, successive governments turned to the medical profession, the pharmaceutical industry and the patient for help.

However, as discussed below, efforts in these directions had few of the desired effects as representatives of the medical profession were unlikely to agree to policy solutions that could affect the interests of family doctors, the pharmaceutical industry may not have complied voluntarily with measures intended to reduce its profits, and patient demands for medicines could not be altered in ways that would deter individuals from consuming the products that they required.

Indeed, from a cost-containment perspective, policies in these areas failed to produce many of the benefits that direct controls or a restructuring of both the prescribing and the dispensing systems may have achieved.

## The prescription charge and after

Soon after the introduction of the NHS, Clement Atlee's Labour government enacted the legislation necessary for the introduction of a 'prescription charge'. Following its election victory in October 1951, Winston Churchill's Conservative government implemented the charge in June 1952 at a rate of one shilling (5p) for each form issued. However, the payment did not produce all of the expected benefits as GPs responded by prescribing more items per form.

Given the charge's failure to substantially control costs, in 1952 the Ministry of Health initiated informal discussions with the Association of the British Pharmaceutical Industry (ABPI) about voluntary means of controlling NHS drug costs.[3] However, as the Guillebaud Committee on NHS spending had been established in October 1951, the Ministry was unable to reach any formal agreements with the industry until after the committee's final report in January 1956.[4]

Given the Guillebaud Committee's pronouncements on NHS expenditure, the Ministry of Health was left to implement its own means of curtailing the sustained growth in public expenditure on drugs. In December 1956, the prescription charge was changed to one shilling per item as a means of removing the incentive for GPs to increase the number of items prescribed on each form. However, the charge did not produce all of the expected savings as family doctors responded by increasing the volume of drugs that they prescribed per item.

Given the limited success of the revised charge, the Ministry turned to the representatives of the pharmaceutical industry and the medical profession for help. Following negotiations with the ABPI, the Voluntary Price Regulation Scheme (VPRS) was introduced in April 1957 (for a trial period of three years), with the intention of making savings in the drugs bill of £750 000 per annum.[3]

## The Hinchcliffe Committee

After discussions with the BMA, the Hinchcliffe Committee was appointed in June 1957 to investigate the factors contributing to the rise in the cost of prescriptions issued under the NHS and to make suitable policy recommendations.

The Hinchcliffe Committee took just under two years to publish its final report, during which time the launch of major new pharmaceutical policies was suspended.[5] The committee considered the training and instruction of medical students and young doctors, the provision of information on new drugs to GPs, the influence of consultants and patients on the prescriber, the doctor's right to prescribe, drug research and development, the pharmaceutical producers and their advertising, the role of the retail pharmacist, charging for prescriptions, restricting quantities issued, and the need for a permanent body to advise the Ministry of Health on matters affecting prescribing economies and costs.

| Year | Dispensing doctors | Prescribing doctors |
|---|---|---|
| 1951/52 | 15s 0d | £1 1s 1d |
| 1952/53 | 14s 10d | £1 2s 6d |
| 1953/54 | 15s 0d | £1 2s 0d |
| 1954/55 | 16s 7d | £1 3s 8d |
| 1955/56 | 18s 0d | £1 5s 8d |
| 1956/57 | 18s 7d | £1 7s 5d |
| 1957/58 | £1 1s 4d | £1 10s 1d |

**Table 1.** Average prescribing costs per patient, 1951–58; after reference 5

### *Prescribing vs dispensing doctors*

As part of its study, the Hinchcliffe Committee examined the arrangements for supplying drugs and reimbursing dispensers in England's urban and rural areas. Following its investigation, the committee reported that all pharmacists were reimbursed on the basis of the rates listed in the *Drug Tariff*.[3] Dispensing doctors, on the other hand, could choose to be paid on the same basis as pharmacists or by means of a capitation fee of 10 shillings (50p) per person per year (with additional payments being available to cover the costs of certain expensive drugs and appliances).

According to the committee, in 1959 the latter option was more popular with approximately 2220 of the country's 2700 dispensing doctors choosing to be paid on this basis.

During its study, the Hinchcliffe Committee found that the capitation system had constrained expenditure on pharmaceuticals. As Table 1 shows, dispensing doctors as a group had lower average prescribing costs per patient than their nondispensing colleagues throughout the 1950s. As a result, the Hinchcliffe committee reported that 'various suggestions have been put forward



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from time to time for bringing prescribing doctors' costs down nearer to those of their dispensing colleagues'.

However, the committee saw 'serious objections' to the introduction of incentive schemes similar to the Floating Sixpence, particularly as 'patients would feel that doctors were being encouraged to practise economy at their expense'.

The Hinchcliffe Committee claimed that some pharmacists and dispensing doctors had been able to purchase a number of drugs significantly below the rates at which they had been reimbursed. Although it acknowledged that there was little wrong with dispensers benefiting from such opportunities, the committee commented that 'those responsible for administering the pharmaceutical service should surely have sufficient business acumen to ensure that the taxpayer shared in some of the savings which could be made'.

As well as examining the system for supplying medicines and reimbursing dispensers in England's urban and rural areas, the Hinchcliffe Committee also investigated a number of factors believed to be contributing to the rise in general practice prescribing costs. For example, the committee examined the influence of hospital consultants on GP prescribing, the pressure for a prescription from patients, and the social determinants of regional variations in expenditure.

Although it analysed much of the available evidence, the committee concluded that the 'main factors influencing the cost of prescriptions were the coincidental introduction of a free comprehensive Health Service for all and the discovery and large-scale production of valuable but expensive drugs'.

*Improving prescribing*

As part of its investigation, the Hinchcliffe Committee also considered whether further steps could be taken to improve the prescribing behaviour of individual GPs. Following an analysis of the pertinent issues the committee concluded that, 'while there is no evidence of widespread and irresponsible extravagance in general practitioner prescribing, there is a scope for economy'. Although it was acknowledged that further economies could be secured, the committee recommended against the automatic substitution of non-proprietary for proprietary products during dispensing as it would have discouraged GPs from learning the generic names of available products.

Instead, among its main policy conclusions, the committee recommended that family doctors should receive systematic postgraduate instruction in pharmacology and therapeutics, and practitioners should be supplied with information about drug prices and should select the least expensive of the appropriate drugs available.

As the above recommendations suggest, the Hinchcliffe Committee believed that the majority of GPs were, intrinsically, rational prescribers but that their rationality was bounded by the information and understanding that they possessed. In consequence, the committee suggested that changes in their postgraduate education and developments in the provision of information would enable family doctors to improve the economy of their prescribing.

However, the committee also acknowledged that, in some instances, practitioners could not be relied upon to control their own costs. It recommended that the BMA should be consulted regarding a tightening of the existing standards for the investigation of excessive prescribing, and agreement should be reached on a voluntary limit to the amount of drugs that should be supplied on one prescription form.

## Savings not achieved

While the Hinchcliffe Committee deliberated, NHS expenditure on pharmaceuticals continued to rise. Since the committee's inception, the Minister of Health's efforts to control the growth in public spending on drugs had been of limited effect. The prescription charge of one shilling per item, introduced in December 1956, had not produced all of the expected benefits, and the VPRS, established in April 1957, failed to generate all of the planned savings.

As many of the policy solutions offered by the Hinchcliffe Committee would only be effective in the longer term, the Minister was, again, forced to look to the pharmaceutical industry and the patient for help. In consequence, the VPRS was renegotiated in December 1960 and the prescription charge was doubled from one to two shillings (10p) per item in March 1961. However, as had previously been the case, the measures failed to produce all of the expected savings.

## References

Full references are available on the *Prescriber* website: www.prescriber.co.uk.

*Darrin Baines is associate professor, Faculty of Medicine and Health Sciences, University of Nottingham*

The next article in this series will look at Labour and Conservative prescribing policies, 1964–79.

## Letters

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